EXHIBIT A

Neurology Associates, Ltd.
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Stephen E. Reznak, M.D.
Dan Gzesh, M.D.

Lorenzo G. Runk, M.D.
Debashis Biswas, M.D.

July 25, 2000

Lee Silverman, M.D.
1500 Lansdowne Avenue
Darby, PA 19023

RE: ARTHUR JACKSON, III

Dear Lee:

I had the pleasure of seeing Mr. Jackson in follow up. I had seen him several years ago,. when he was hospitalized. As you know, there is a history of epidural spinal cord compression with paraparesis.

I reviewed records from Crozer-Chester where he presented in May with a serious head injury. According to witnesses, he had simply dropped over, and there was no convulsion at the scene. He suffered a subdural hematoma, with subarachnoid hemorrhage as well, and was treated for a number of days conservatively. He was ultimately discharged on Dilantin, although elected not to take it.

An electroencephalogram, performed at that time, was within normal limits.

He has had no recurrent seizures, and states that he is no longer using alcohol.

He is concerned about a number of current problems. These include memory loss, speech dysfunction, headache, dysequilibrium, and depression. He has been treated with a number of medications, as you know, but has remained quite distraught.

On examination today he is tearful, with an inappropriately exuberant affect. There is quite a wide range of emotional lability, with very brief intervals between them. He became tearful on multiple occasions.

His gait is quite tentative. His reflexes are symmetrically hypoactive.

We had a long discussion concerning the advisability of anti-convulsant therapy. I recommended repeating his electroencephalogram, but have to concur, at this time, that there is no evidence of an epileptic disorder.

RE: ARTHUR JACKSON, III

He notes that he had suddenly stopped his clonazepam several days prior to his fall, which had occurred while he was in prison. He inquired whether this may have been responsible, and I stated that it is a possibility.

He will continue his other medications, as prescribed by you, including Clonazepam, 5 mg. daily, Effexor, 600 mg. daily, Trazodone, 200 mg. q HS, and the insulin as prescribed.

I would like to see him again after the electroencephalogram.

Thank you for allowing me to share in his care.

Sincerely yours,

Dan J. Gzesh, M.D.

DJG:bb
cc: Celsus Ebba, M.D.
869 Main Street
Darby, PA 19023

Robert C. O'Reilly, M.D.
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Darby, PA 19023

EXHIBIT B

JAMES F. MENAPACE, M.D.
341 E. Casals Place
Ambler, PA 19002
Telephone: (215) 653-0270

May 27, 2003

David F. White, Esquire
Kelly, McLaughlin, Foster, Bracaglia,
Daly, Trabucco & White, LLP
620 West Germantown Pike
Suite 350
Plymouth Meeting, PA 19462-1056

RE: Jackson vs Wackenhut, et al.

Dear Mr. White:

As you requested, I have reviewed the following records concerning the medical and psychiatric treatment of Mr. Arthur Jackson: records from Crozer Chester Medical Center, admission date 5/28/00, discharge date 6/3/00; records from Crozer Chester Medical Center, admission date 6/4/00, discharge date 6/7/00; medical records from Lee D. Silverman, M.D., multiple records concerning Dr. Silverman's care of Mr. Jackson for approximately two years; medical records from Celsus Ebba, M.D., Mr. Jackson's family physician, these are records of office visits and laboratory records of Arthur Jackson over several years; deposition transcription of Arthur Jackson, Part I, February 20, 2003, and Part II, March 17, 2003. Also reviewed was a report from Rehab Nurse Consultants dated February 20, 2003, prepared by Betsy Bates, B.S. Also sent to me were reports concerning Mr. Jackson's prescriptions received from CVS Pharmacy as well as from The Medicine Shoppe, another pharmacy.

Mr. Arthur Jackson was incarcerated at Delaware County Prison on 5/26/00, apparently around 5:00 p.m. Friday evening and preparing for release on Sunday, 5/28/00, at 6:00 p.m. in the evening when this unfortunate individual either fell down or had a seizure resulting in a head injury.

My review of the records from Crozer Chester Medical Center are somewhat confusing in that the trauma attending admission record states that the patient was a forty-seven year old African American male prisoner, fell down, seizure for three minutes, questionable loss of consciousness, now complaining of headache. This sheet is dated 5/28/00 at 7:15 p.m., and the mechanism of injury is called a fall. A second sheet, a history sheet from Crozer Chester Medical Center dated 5/28/00, states that Mr. Jackson fell from a standing position and hit his head with a positive loss of consciousness and a positive seizure, now with bleeding from his head.

Review of the medical records reveal that Mr. Jackson did suffer a significant head injury, the mechanism, whether this was fall or seizure is unclear. His diagnosis at the time of admission to Crozer Chester Medical Center is that of a right subdural hematoma, right frontal lobe contusion and possible basilar skull fracture. Upon his arrival, the patient is treated as a trauma patient. He

had complete evaluations concerning his medical condition. He undergoes a CAT scan of the head and the abdomen, has x-rays of his cervical spine as well as a CAT scan of his cervical spine, has blood work as well as urine samples sent to the lab. His urine was sent for a urine drug screen at that time. Of note is that Mr. Jackson also had an alcohol level sent which was reported as zero. The urine drug screen was negative for amphetamines, barbituates, benzodiazepams, THC, cocaine metabolites, opiates and PCP. Insulin for the patient's blood glucose was 461, as stated before, on admission to the Emergency Room. Of interest was that Mr. Jackson was noted to be awake and alert and oriented. He responded appropriately, followed commands and was found, according to the medical records, to have no neurologic deficits at that time. His Glasgow Coma Scale was 15, which is essentially normal.

The patient was able to give an adequate medical history according to the in-patient records of that day of 5/28/00. It is recorded that he is able to give a medical history of having diabetes, depression and able to tell the staff his medications. Also of note is that the patient's serum sodium at the time of admission to Crozer Chester Medical center was recorded as 126, being somewhat low with the normal value being 135 to 146 MMOL/L. Mr. Jackson is admitted to the Intensive Care Unit where he undergoes conservative therapy in the sense that no surgical interventions took place nor did he require any specialized treatment besides observation and the addition of Dilantin to prevent seizures. The patient was seen by various consultants while in the Intensive Care Unit and in the hospital and is subsequently discharged to the rehabilitation on 6/3/00.

I also reviewed records from Dr. Silverman, Mr. Jackson's psychiatrist. There are multiple notes from Mercy Psychiatric Associates dating from 1999 until most recently, April of 2003. Dr. Silverman's diagnosis is, on several of the sheets, and these are at the top of his progress notes, and they are highlighted as diagnosis/target symptoms, several diagnoses are stated that of depression, anxiety, ethanol abuse and insomnia. It appears from the records that Dr. Silverman has followed Mr. Jackson for several years and prescribed medications such Klonopin, Effexor and Trazadone.

There is no mention of seizure disorder in the records that I reviewed from Dr. Silverman. Also reviewed was a three page letter apparently dictated by Dr. Silverman addressed to Mr. John L. Rollins dated January 1, 2003, in which Dr. Silverman talks about his relationship with Mr. Jackson and his treatment of Mr. Jackson. In his letter to Mr. Rollins, Dr. Silverman answers a question, and I will quote the question, "Do you agree that the injuries (subdural hematoma with subarachnoid hemorrhage) for which you have been treating him since May 29, 2000, were caused by the deprivation of physician prescribed medications (i.e., Insulin, Klonopin, etc.) while Mr. Jackson was incarcerated in Delaware County Prison?" Dr. Silverman answers, and I quote, "It is my understanding that Mr. Jackson was not given his psychiatric medications or his Insulin. Given that Mr. Jackson was not intoxicated at the time nor was he drinking on a regular basis, it is my belief that the seizure was more than likely due to abrupt cessation of the Klonopin and lack of Insulin. I do remember faxing Mr. Jackson's psychiatric medication records to the

nurse or physician in the prison so they would have had an updated record of the medications that I was prescribing for him."

After review of the medical records concerning Mr. Jackson's past medical history and psychiatric history, I disagree with Dr. Silverman that the seizure was more than likely due to an abrupt cessation of Klonopin and the lack of Insulin. First and foremost is that the patient's blood glucose at the time of admission to Crozer Chester Medical Center was 461. This is an elevated glucose. There is nothing in the medical literature to support seizures or falls because of an elevated glucose in the 400's. Had the patient taken too much Insulin and his glucose was low, less than 70, then the possibility of a seizure would be considered. To my medical knowledge after twenty years of emergency medicine practice, I have never encountered nor read of a case of a patient having a seizure due to a lack of Insulin and a blood glucose of 461. I also disagree with Dr. Silverman's conclusion that the abrupt withdrawal of Klonopin was the reason for the patient's head trauma. My reasoning for disagreeing with him is first the urine drug screen performed at Crozer Chester Medical Center on Mr. Jackson's urine when he arrived in the Emergency Room. The records reveal that the urine drug screen was negative and there were no detectable benzodiazapam metabolites in Mr. Jackson's urine. The pharmacology of benzodiazapam metabolism is such that if Mr. Jackson had been taking his Klonopin, as he states, daily, in the doses provided which were therapeutic, three times a day, then there would have been detection of benzodiazapams in his urine. I refer you to an enclosure called, Drug Detection Time In Urine Following Last Dose. This is from Quest Diagnostics out of Cambridge, Massachusetts, Quest Diagnostics being one of the largest national reference laboratories.

The sheet reflects that after acute use, benzodiazapams would be detected in the urine for up to three days and chronic use would be up to four to six weeks. It is my understanding that Dr. Silverman prescribed Klonopin for Mr. Jackson on a daily basis. Had Mr. Jackson been taking his Klonopin as prescribed, it is more likely that he would have had benzodiazapams detected in his urine. This leads me to conclude that it had been at least several days since Mr. Jackson had not taken his Klonopin and at least three days in the acute phase, yet he was treated on a regular basis and I would expect that his benzodiazepams would be detectable in his urine for weeks afterwards because of the pharmokinetics of benzodiazapam metabolism if used in a therapeutic dose as prescribed for Mr. Jackson.

Simply put, it appears to me that, after review of the medical records, Mr. Jackson had not taken Klonopin in quite a while since his urine drug screen was negative for benzodiazapams, there was no detectable threshhold level for benzodiazapams in his urine and again, if you read, the Quest Diagnostics reference sheet concerning urine benzodiazapams, that should have been detectable. I also refer to you to Clinical Management of Poisoning and Drug Overdose, Second Edition, by Lester M. Haddad, M.D., F.A.C.E.P. and James F. Winchester, M.D., F.R.C.E.P., W.B. Saunders Co., page 58, Laboratory Diagnosis and Drug Testing. There is a chart which is labled "Table 36, with the heading "Approximate Duration of Detectability of Selected Drugs in

the Urine." Under the drugs is listed benzodiazapam and there is a three day approximate duration of detectablility.

Again, I base my argument and my conclusion on these reference texts and references from diagnostic labs that if Mr. Jackson had been taking his Klonopin the week prior to his admission to Delaware County Prison, his urine drug screen should have been positive for benzodiazapams. My opinions are made with a reasonable degree of medical certainty.

The third argument against this being a result of the patient not receiving his Klonopin during the two days of incarceration at Delaware County Prison, is that Mr. Jackson did not manifest any of the symptoms of benzodiazapam withdrawal. I am assuming that Dr. Silverman attributes Mr. Jackson's head injury to a questionable seizure or fall as the result of abrupt cessation and I am assuming he means withdrawal of benzodiazapams. Unfortunately, if you read the literature, the syndrome of benzodiazapam withdrawal is very similar to that of alcohol withdrawal. Patients who withdraw from benzodiazapams can show increased anxiety, apprehension, agitation, tremors, headaches and less common symptoms are that of nausea, vomiting and palpitations. Seizures have been reported, and may occur up to two weeks following cessation or stoppage of benzodiazapams. Again, I base my argument that this was not related to Mr. Jackson's not receiving his Klonopin for two days while in Delaware County Prison because of his lack of symptoms of benzodiazapam withdrawal when he was admitted to Crozer Chester Medical Center. There is no mention of benzodiazapam withdrawal during his hospitalization as a result of his fall. I also support my contention that Mr. Jackson had stopped his Klonopin well before his incarceration of May 26, 2000, with reference to the letter to John Rollins, Esquire, from Dr. Gzesh. I quote the second paragraph in Dr. Gzesh's letter to Mr. Rollins, "He currently suffers from the neurologic sequelae of a severe head injury. I believe the injury, a subdural hematoma, was related to the deprivation of Clonazapam which he had been receiving on a chronic bases, which led to a seizure and subsequent head injury." Again, it is my medical opinion with a reasonable degree of medical certainty that Mr. Jackson was not taking his Klonopin as directed. Had he been taking it daily on a chronic basis for his depression and anxiety, then his urine drug screen would have been positive for benzodiazapams at the time of admission to Crozer Chester Medical Center on May 28, 2000, when he suffered his fall or seizure resulting in his head injury.

Review of Dr. Silverman's progress notes concerning the treatment of Mr. Jackson also reveal that Mr. Jackson was abusing alcohol well before his accident in which he fell and suffered a head injury on May 28, 2000. Another possible cause for Mr. Jackson's fall or seizure could have been acute alcohol withdrawal. Mr. Jackson was in the Delaware County Prison from May 26, 2000 to May 28, 2000, and I must assume that he was not allowed to drink alcohol during that period seeing that he was incarcerated for DUI at that time. It is conceivable that Mr. Jackson acutely withdrew and the resultant fall or seizure was again the result of alcohol withdrawal and subsequently leading to Mr. Jackson's injuries.

It is my further opinion that had Mr. Jackson been taking Klonopin the week prior to his weekend incarceration beginning May 26, 2000, his urine drug screen should have been positive for benzodiazapams and further, if he had been taking Klonopin on a regular, therapeutic basis, benzodiazapams would be detectable in his urine for weeks. I must therefore conclude that Mr. Jackson had not taken Klonopin in quite a while as his urine drug screen was negative for benzodiazapams. Additionally, it is conceivable that Mr. Jackson's fall or seizure was the result of alcohol withdrawal.

All of the above opinion are made with a reasonable degree of medical certainty.

If I can be of any further assistance in this matter, do not hesitate to contact me.

Respectfully submitted,

James F. Menapace, M.D., F.A.C.E.P.

JFM/me

DRUG DETECTION TIME IN URINE FOLLOWING LAST DOSE

The duration of excretion of detectable amounts of drug in the urine following last intake is highly variable. A general rule of thumb is five plasma half-lives. This is simply a rough estimate given the following variables: route of administration, amount of drug taken, frequency of use, individual metabolism, urinary pH, and drug storage within body.

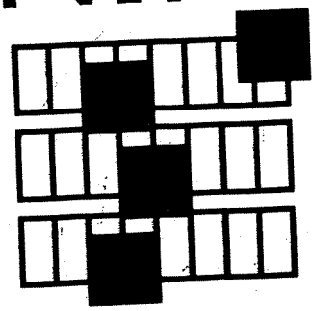
The usual drug screen includes the tests below

DRUG	DETECTION TIME IN URINE	
	ACUTE USE	CHRONIC USE
Amphetamines	one day	several weeks
Barbiturates	short acting (e.g. Seco): one day long acting (e.g. Pheno): 2-3 weeks	
Benzodiazapenes	3 days	4-6 weeks
Cocaine Metabolites	2-3 days	several days
Codeine/Morphine	2-4 days	several days
Methadone	2-3 days	1-2 weeks
PCP	up to 1 week	1-2 weeks
Propoxyphene	1-2 days	several days
Marijuana	single smoke: up to 4 days moderate use: up to 10 days heavy use up to 4-6 weeks passive inhalation: negative	
Nicotine	moderate use: 1-2 days	

SOURCE: Quest Diagnostics, Cambridge, Massachusetts

Clinical Management of

POISONING AND DRUG OVERDOSE



Second Edition

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W.B. SAUNDERS COMPANY
Harcourt Brace Jovanovich, Inc.
Philadelphia ■ London ■ Montreal ■ Toronto ■ Sydney ■ Tokyo

Table 3–6. APPROXIMATE DURATION OF DETECTABILITY OF SELECTED DRUGS IN URINE

DRUG	APPROXIMATE DURATION OF DETECTABILITY*	LIMITS OF SENSITIVITY OF ANALYTIC TECHNIQUES (μmol/L)
amphetamine	48 hr	0.5 μg/ml
methamphetamine	48 hr	0.5 μg/ml
barbiturates	24 hr	
Short-acting:		
hexobarbital		1.0 μg/ml
pentobarbital		0.5 μg/ml
secobarbital		0.5 μg/ml
thiamylal		1.0 μg/ml
Intermediate-acting:	48–72 hr	
amobarbital		1.0 μg/ml
aprobarbital		1.5 μg/ml
butabarbital		0.5 μg/ml
butalbital		1.5 μg/ml
Long-acting:	≥ 7 days	
barbital		5.0 μg/ml
phenobarbital		1.0 μg/ml
benzodiazepines	3 days†	1.0 μg/ml
cocaine metabolites	2–3 days	
benzoylecgonine		0.5 μg/ml
ecgonine methyl ester		1.0 μg/ml
methadone	≈ 3 days	0.5 μg/ml
1,5-dimethyl-3,3-diphenyl-2-ethylidene pyrrolidine (metabolite of methadone)	≈ 3 days	
codeine	48 hr	0.5 μg/ml
morphine		0.5 μg/ml
propoxyphene	6–48 hr	1.0 μg/ml
norpropoxyphene		0.5 μg/ml
cannabinoids	3 days,‡ 5 days§	1.5 μg/ml
(11-nor-9-tetra-hydrocannabinol-9-carboxylic acid)	10 days‖	
methaqualone	21–27 days¶	20 ng/ml
phencyclidine	≥ 7 days	1.0 μg/ml
	≈ 8 days	0.5 μg/ml

*Interpretation of the duration of detectability must take into account many variables, such as drug metabolism and half-life; subject's physical condition, fluid balance, and state of hydration; and route and frequency of ingestion. These are general guidelines only.

†Using therapeutic dosages.

‡Single use.

§Moderate smoker (4 times per week).

‖Heavy smoker (smoking daily).

¶Chronic heavy smoker.

(From Report of Council on Scientific Affairs: Scientific issues in drug testing. JAMA 257:3110–3114, 1987. Copyright 1987, American Medical Association.)

best approach would be the multilaboratory analyses of an authentic plasma or urine sample, with comparison to duplicate laboratory GC-MS analyses as the reference. Such materials are now becoming available as a result of proficiency testing programs that produce survey-validated samples. The Forensic Urine Drug Testing (FUDT) progam is jointly administered by the American Association of Clinical Chemistry (AACC) and the College of American Pathologists. It provides Pathologists also sponsors toxicology survey programs with both serum and urine specimens. In addition, the military and various states provide such programs.

Workplace Drug Testing. In recent years, workplace (employee) drug testing of urine and other nonclinical substance-abuse testing (athletic programs, the military, correctional facilities, etc.) have become widespread. In order not to jeopardize the livelihood and due process rights of the individuals being tested, laboratories must produce results that

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EDUCATION:

1976-1980	Doctor of Medicine Temple University, School of Medicine Philadelphia, Pennsylvania
1975	Temple University, Graduate Studies Philadelphia, Pennsylvania
1969-1972	Bachelor of Science Kings College Wilkes-Barre, Pennsylvania

POST GRADUATE TRAINING AND FELLOWSHIP APPOINTMENTS:

1980-1981	Internal Medicine Internship Temple University Hospital Philadelphia, Pennsylvania
1981-1983	Internal Medicine Residency Temple University Hospital Philadelphia, Pennsylvania

SPECIALTY CERTIFICATIONS:

1983	American Board of Internal Medicine Diplomate, American College of Physicians
1988	American Board of Emergency Medicine Diplomate, American Board of Emergency Medicine
1989	Fellow, American College of Emergency Physicians
1995	Certified Medical Review Officer Medical Review Officer Certification Council
1998	Re-certification Examination American Board of Emergency Medicine Diplomate, American Board of Emergency Medicine

CERTIFICATIONS:

	American Heart Association
1983, 85, 87, 93	Advanced Cardiac Life Support Provider
1990	Advanced Cardiac Life Support Instructor
	American College of Surgeons
1985	Advanced Trauma Life Support Provider
1988	Advanced Trauma Life Support Instructor

HOSPITAL APPOINTMENTS:

6/83-9/83	Attending Staff, Emergency Department Burdette Tomlin Memorial Hospital Cape May Courthouse, New Jersey
10/83-7/87	Attending Staff, Emergency Department Sacred Heart Hospital Norristown, Pennsylvania
7/87-Present	Attending Staff, Emergency Department Warminster Hospital Warminster, Pennsylvania

ADMINISTRATIVE APPOINTMENTS:

1988-1991	Associate Director, Department of Emergency Medicine Warminster Hospital Warminster, Pennsylvania
1991-Present	Chairman, Department of Emergency Medicine Warminster Hospital Warminster, Pennsylvania
1994-Present	Director, Occupational Health Warminster Hospital Warminster, Pennsylvania

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PROFESSIONAL ASSOCIATIONS:

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HOSPITAL SERVICE:

1987-1989	Chairman, Disaster Committee Warminster Hospital Warminster, Pennsylvania
1988-1991	Associate Director, Emergency Services Warminster Hospital Warminster, Pennsylvania

HOSPITAL SERVICE:

1990-Present	Physician Advisor Bucks County Emergency Health Council Bucks County, Pennsylvania
1991-Present	Director, Department of Emergency Medicine Warminster Hospital Warminster, Pennsylvania
	Voting Member, Medical Executive Committee Warminster Hospital Warminster, Pennsylvania
1992-1995	Member, Quality Council Warminster Hospital Warminster, Pennsylvania
1993-1995	Chairman, Quality Care Committee Warminster Hospital Warminster, Pennsylvania
	Member, Hospital Operations Warminster Hospital Warminster, Pennsylvania
1996-1999	Physician Advisor Enterprise Fire Company Hatboro, Pennsylvania
1997-Present	Bucks County Regional Medical Director Bucks County Emergency Health Council, Inc. Doylestown, Pennsylvania
1996-1998	Medical Director, Telephone Answering Nurse Triage Service Allegheny Health, Education and Research Foundation
1997-1998	Member, Ambulatory Quality Improvement Committee Allegheny Health, Education and Research Foundation
1998-Present	Vice-President, Medical Staff Warminster Hospital